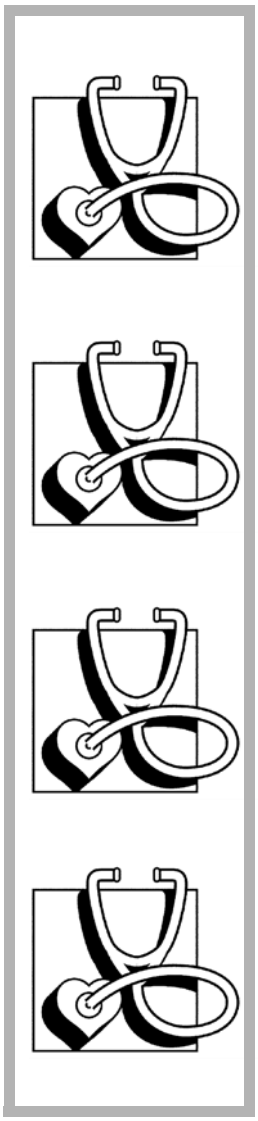


# *Hospice Care Services*

## *Medicaid and Other Medical Assistance Programs*

MONTANA
Department of Public Health & Human Services

**January 2005**

*This publication supersedes all previous Hospice Care Services manuals. Published by the Montana Department of Public Health & Human Services, July 2004.*

*Updated January 2005.*



**My Medicaid Provider ID Number:**

MONTANA
Department of Public Health & Human Services

# Table of Contents

# Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated "In state" will not work outside Montana.

## Provider Relations

For questions about eligibility, payments, denials, general claims questions, Medicaid or PASSPORT provider enrollment, address or phone number changes, or to request provider manuals or fee schedules:

**(800) 624-3958** In state
**(406) 442-1837** Out of state and Helena

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

## Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

## Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

## Senior and Long Term Care

For hospice program information:

**(406) 444-4064** Phone
**(406) 444-7743** Fax

Send written inquiries to:

Senior and Long Term Care
P.O. Box 4210
Helena, MT 59604

## Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

**(800) 624-3958** In state
**(406) 443-1365** Out of state and Helena
**(406) 442-0357** Fax

Send written inquiries to:

ACS Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

## Provider's Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the G*eneral Information For Providers* manual.

## Technical Services Center

Providers who have questions or changes regarding electronic funds transfer should call the number below and ask for the Direct Deposit Manager.

**(406) 444-9500**

## ACS EDI Gateway

For questions regarding electronic claims submissions:

**(800) 987-6719** Phone
**(850) 385-1705** Fax

ACS EDI Gateway Services
2324 Killearn Center Blvd.
Tallahassee, FL 32309

## Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

**(406) 444-2055** Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

## Key Web Sites

| Web Address | Information Available |
|---|---|
| **Virtual Human Services Pavilion (VHSP)**<br><br>vhsp.dphhs.mt.gov | **Select *Human Services* for the following information:**<br>• **Medicaid:** Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information.<br>• **Senior and Long Term Care:** Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning.<br>• **DPHHS:** Latest news and events, Mental Health Services Plan information, program information, office locations, divisions, resources, legal information, and links to other state and federal web sites.<br>• **Health Policy and Services Division:** Children's Health Insurance Plan (CHIP), Medicaid provider information such as manuals, newsletters, fee schedules, and enrollment information. |
| **Provider Information Website**<br>www.mtmedicaid.org<br>or<br>www.dphhs.mt.gov/hpsd/medicaid/medicaid2 | • Medicaid Information<br>• Medicaid news<br>• Provider manuals<br>• Notices and manual replacement pages<br>• Fee schedules<br>• Remittance advice notices<br>• Forms<br>• Provider enrollment<br>• Frequently asked questions (FAQs)<br>• Upcoming events<br>• Electronic billing information<br>• Newsletters<br>• Key contacts |
| **Medicaid Mental Health and Mental Health Services Plan**<br>www.dphhs.mt.gov/about_us/divisions/addictive_mental_disorders/services/public_mental_health_services.htm | Mental Health Services information for Medicaid and MHSP |
| **Senior and Long Term Care**<br>http://www.dphhs.mt.gov/sltc/index.htm | • Provider Search<br>• Home/Housing Options<br>• Healthy Living<br>• Government Programs<br>• Publications<br>• Protective/Legal Services<br>• Financial Planning |
| **ACS EDI Gateway**<br>www.acs-gcro.com/Medicaid_Account/Montana/montana.htm | ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on:<br>• Provider Services<br>• EDI Support<br>• Enrollment<br>• Manuals<br>• Software<br>• Companion Guides |
| **Washington Publishing Company**<br>www.wpc-edi.com | • EDI implementation guides<br>• HIPAA implementation guides and other tools<br>• EDI education |

MONTANA
Department of Public Health & Human Services

# Introduction

Thank you for your willingness to serve clients of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

## Manual Organization

This manual provides information specifically for providers of hospice services. Additional essential information for providers is contained in the separate *General Information For Providers* manual. Each provider is asked to review both manuals.

A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. Each manual contains a list of *Key Contacts* at the beginning. We have also included a space on the back side of the front cover to record your Medicaid Provider ID number for quick reference when calling Provider Relations.

## Manual Maintenance

Manuals must be kept current. Changes to manuals are provided through notices and replacement pages. When replacing a page in a manual, file the old pages and notices in the back of the manual for use with claims that originated under the old policy.

## Rule References

Providers are responsible for knowing and following current laws and regulations.

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. In the event that a manual conflicts with a rule, the rule prevails. Links to rules are available on the Provider Information website (see *Key Contacts*). Paper copies of rules are available through Provider Relations, the Department (Senior and Long Term Care) and the Secretary of State's office (see *Key Contacts*). In addition to the general Medicaid rules outlined in the *General Information For Providers* manual, the following rules and regulations are also applicable to the hospice program:

- Code of Federal Regulations (CFR)
  - 42 CFR 418 Hospice Care
- Montana Codes Annotated (MCA)
  - MCA 53-6-101 Montana Medicaid Program Authorization of Services

- Administrative Rules of Montana (ARM)
  - ARM 37.40.801 - 37.40.830 - Hospice

## Claims Review (MCA 53-6-111, ARM 37.85.406)

The Department is committed to paying Medicaid provider's claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

## Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer or Provider Relations). The list of *Key Contacts* at the front of this manual has important phone numbers and addresses pertaining to this manual. The *Introduction* chapter in the *General Information For Providers* manual also has a list of contacts for specific program policy information. Medicaid manuals, notices, replacement pages, fee schedules, forms, and much more are available on the Provider Information website (see *Key Contacts*).

# Covered Services

## General Coverage Principles

Hospice programs provide health and support services to terminally ill clients and their families. These programs focus on palliative rather than curative care to help the client and those closest to the client come to terms with the terminal condition and live the remaining life as fully as possible.

When a client selects hospice, he or she waives all Medicaid benefits related to curative care. The client may receive palliative services provided by the designated hospice, the client's attending physician, or room and board by a nursing facility if the client is a resident. This chapter provides information on covered services supplied by hospice providers. Like all health care services received by Medicaid clients, services provided by hospice providers must also meet the general requirements listed in the *Provider Requirements* chapter of the *General Information For Providers* manual.

### *Services provided by the hospice (ARM 37.40.805)*

- The hospice must be licensed under state law.
- The hospice must meet Medicare's conditions of participation and have a valid provider agreement with Medicare.
- The hospice must provide the Department with a list of physician volunteers and physicians employed by the hospice. This list must be kept current.
- The hospice must notify the Department when the client's attending physician is not a hospice employee.

### *Services provided by physicians (ARM 37.40.801)*

Physician services are defined as those services provided by individuals licensed under their state medical practice act to practice medicine or osteopathy.

### *Services provided by contract staff (42 CFR 418.90)*

A hospice may use contracted staff to supplement hospice employees during periods of peak client loads or other extraordinary circumstances. The hospice remains responsible for the quality or services provided by contracted staff.

### *Non-covered services*

- Medicaid will not pay separately for palliative services. It is the responsibility of the hospice to provide all palliative treatment, which is included in the hospice daily rate.

- Services used for curative care are not covered by the hospice or by Medicaid for hospice clients. For example, chemotherapy and radium are not covered for curative purposes but may be provided by the hospice when the purpose is to make the client more comfortable.
- Services provided by a hospice other than the elected hospice are not covered. However, services provided by a provider (or another hospice) other than the hospice or the client's attending physician are only covered when the hospice has a contract with the provider.
- Medicaid does not cover physician services provided on a volunteer basis.

## Client Enrollment

Hospice services are covered only for Medicaid clients enrolled in the hospice program. The following are client enrollment policies.

- The Medicaid client must be certified as terminally ill, and certification must be submitted to Medicaid (see *Physician's certification* in following table).
- During the election process, the hospice must explain the benefits the client will receive and those the client is waiving (see *Election statement* in following table).
- The hospice must establish a plan of care for the client (see *Plan of care* in following table).
- A client may receive hospice care until he or she is no longer certified as terminally ill or until the election of hospice is revoked (see *Revocation statement* in following table).
- The hospice must obtain certification of the client's terminal illness for two consecutive 90-day periods followed by an unlimited number of 60-day periods (see *Physician's certification statement and Physician's recertification statement* in following table).
- A client may change hospice providers once in each election period. The client submits a signed statement identifying the current hospice and the newly designated hospice. This statement must give the effective date of change. Both hospices must retain copies of this statement.
- A client may revoke the election of hospice at any time. After revoking hospice election, the client may receive any Medicaid benefits previously waived when hospice care was chosen.
- A Medicaid client may elect hospice again at any time as long as the client meets the hospice eligibility requirements.
- A client may live either in his or her home in the community or in a nursing facility while receiving hospice services.
- Hospice providers must provide their own forms which must meet the requirements shown in the following table.
- See also the *Provider Requirements* chapter in this manual.

## Hospice Form Requirements

**See Appendix A For Sample Forms**

| Form | Requirements |
|---|---|
| **Plan of care** | • The interdisciplinary group must assess the client's needs and develop a written plan of care.<br>• The group member who writes the plan must confer with at least one physician or nurse member of the group while developing the plan.<br>• The other group members must review the client's plan of care.<br>• The hospice must provide services in accordance with the plan. |
| **Election statement** | • The election statement must include the following:<br>  • Name of the hospice that will provide care.<br>  • An acknowledgment that the client understands that hospice provides palliative care, not curative, for the terminal illness.<br>  • An acknowledgment that certain other Medicaid services are being waived when hospice is elected.<br>  • The client's or representative's signature.<br>• A representative may be used for a client who is physically or mentally incapacitated. The representative may sign the election statement, sign the waiver of benefits or revocation statements, or change hospice providers on behalf of the client.<br>• The hospice must submit a copy of the election statement(s) to the Department's Senior and Long Term Care Division (see *Key Contacts*), and give a copy to the client. |
| **Revocation statement** | • The revocation statement must include the following:<br>  • Effective date for the revocation of Medicaid hospice care.<br>  • The client's or representative's signature.<br>• The effective date of the revocation must be on or after the date the form is signed.<br>• Copy of form must be mailed to the Department's Senior and Long Term Care Division (see *Key Contacts*) within two business days after hospice receives the statement. |
| **Physician's certification statement** | • The hospice obtains and documents the certification of terminal illness.<br>• The certification must be obtained verbally within two calendar days after hospice care is initiated.<br>• Written certification must be obtained before billing Medicaid for services. Failure to obtain certification in a timely manner may result in the provider repaying the Department for claims.<br>• The initial certification is for 90 days.<br>• The initial certification must be signed by the medical director of the hospice or the physician member of the interdisciplinary group and the client's attending physician, if he or she has one. |
| **Physician's recertification statement** | • The hospice must obtain a recertification statement stating that the client is terminally ill.<br>• Verbal recertification must be obtained within two calendar days from the beginning of each subsequent benefit period as defined by Medicare regulations.<br>• Written certification must be on file before submitting a claim. Failure to obtain recertification in a timely manner may result in the provider repaying the Department for claims.<br>• The form must be signed by the medical director of the hospice or the physician member of the hospice's interdisciplinary group or the client's attending physician, if he or she has one.<br>• Certification and the first recertification periods are for 90 days and can be followed by an unlimited number of 60-day extensions. |

## Coverage of Specific Services

The hospice must provide all services necessary for the palliation or management of the terminal illness and related conditions. Medicaid generally covers services that are covered under Medicare. In cases where Medicaid and Medicare policies are different, Medicaid policy applies. Medicaid also covers non-curative services that are not provided by the designated hospice such as insulin for diabetics. A hospice is required to provide the following services through the hospice or under contract with another provider. All palliative services, including the following, are included in the daily rate.

### *Counseling services*

Counseling services are provided to the client and the family members or others caring for the client at the client's home. The hospice will train the client's family or other caregiver to provide care and to help the client and those caring for the client to adjust to the person's approaching death. Counseling services also include dietary, spiritual, bereavement, and other counseling. Bereavement counseling is provided for up to one year following the client's death and is available to the client's family and those close enough to the client to be considered family.

When a client is receiving short-term care in a nursing facility during a crisis period, 24-hour nursing services must be provided for the client.

### *Crisis services*

Continuous home care is provided only during a period of crisis. A period of crisis is a period in which a person requires continuous care to achieve palliation or management of acute medical symptoms. Nursing care during a crisis must be provided by a registered nurse or licensed practical nurse. A minimum of eight hours of nursing care must be provided during a 24-hour day, with more than 50% of the care provided by licensed nurses. Home health aide and homemaker services may also be provided to supplement the nursing care during a period of crisis. The eight hours of nursing care does not have to be contiguous throughout the 24-hour period.

### *Home health aide services*

Home health aides may provide personal care services such as bathing, dressing, grooming, etc. Aides may perform household services to maintain a safe and sanitary environment in areas of the home used by the client, such as changing bed linens or light cleaning and laundering essential to the comfort and cleanliness of the client. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in maintenance of a safe and healthy environment and services to enable the provider to carry out the treatment plan.

### *Inpatient hospice care*

Inpatient hospice care is provided when a client's symptoms become too severe for caregivers to manage at home. Inpatient hospice care includes procedures necessary for pain control or acute or chronic symptoms management. Care must be provided in a Medicaid/Medicare certified hospital or a skilled nursing facility under contract with the hospice.

### *Inpatient respite care*

The hospice may provide inpatient respite care for the client's family or others caring for the client at home. The facility must also provide treatments, medications, and diet as prescribed. Inpatient respite care must be provided in an inpatient hospice unit or a Medicaid/Medicare certified hospital or nursing facility under contract with the hospice. The hospice is paid for up to five consecutive days of respite care at a time. Medicaid does not cover respite care when the client lives in a nursing facility.

### *Medical supplies*

Medical appliances, durable medical equipment and supplies including drugs and biologicals, and other self-help and personal comfort items related to the palliation or management of the client's terminal illness are included in the hospice payment. The hospice must provide these supplies for use in the client's home while he or she is receiving hospice care. Medical supplies must be specified in the written plan of care. When a client requires medication that is not related to their terminal condition and not curative (e.g., insulin), it will be covered by the client's Medicaid pharmacy benefits.

### *Nursing services*

The hospice must employ a registered nurse to coordinate client care so that all the client's needs are met. During a crisis period (see *Definitions*), nursing services must be provided directly to the client by a registered nurse (see *Crisis services* earlier in this chapter). Inpatient hospice and respite facilities must have a registered nurse available within the facility 24 hours a day.

### *Physician services*

The hospice must employ a physician as the hospice director and/or to provide medical care that is not being met by the client's attending physician. These services are included in hospice daily rate and are not billed separately.

Services provided by the client's attending physician are covered when the services are palliative only and not related to the treatment of the terminal (or related) condition for which the hospice care was elected. For example, a client who has diabetes may be treated for it by his or her attending physician. All drugs directly related to the terminal condition or for pain are prescribed by the client's attending physician (or hospice director if the client has no attending physician) and supplied by the hospice. When the client is treated by his or

her attending physician, the physician bills Medicaid separately from the hospice and this fee is not included in the hospice cap. When billing Medicaid for physician services, refer to the *Physician Related Services* manual.

### *Social worker services*

Medical social services must be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

### *Therapy services*

Physical therapy, occupational therapy, and speech/language pathology services may be provided to maintain activities of daily living and basic functional skills.

## Other Programs

This is how the information in this manual applies to Department programs other than Medicaid.

### *Mental Health Services Plan (MHSP)*

The information in this manual does not apply to the Mental Health Services Plan (MHSP). Clients who qualify for MHSP may receive mental health services during hospice care. For more information on the MHSP program, see the *Mental Health Manual* available on the Provider Information website (see *Key Contacts*).

### *Children's Health Insurance Plan (CHIP)*

The information in this manual does not apply to CHIP clients. For a CHIP medical manual, contact BlueCross BlueShield of Montana at (800) 447-7828 x8647. Additional information regarding CHIP is available on the CHIP website (see *Key Contacts*).

MONTANA
Department of Public Health & Human Services

# Coordination of Benefits

## When Clients Have Other Coverage

Medicaid clients often have coverage through Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers should bill other carriers before billing Medicaid, but there are some exceptions (see *Exceptions to Billing Third Party First* in this chapter). Medicare is processed differently than other sources of coverage.

## Identifying Additional Coverage

The client's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers (see the *General Information For Providers* manual, *Client Eligibility and Responsibilities*). If a client has Medicare, the Medicare ID number is provided. If a client has additional coverage, the carrier is shown. Some examples of third party payers include:

- Private health insurance
- Employment-related health insurance
- Workers' Compensation Insurance*
- Health insurance from an absent parent
- Automobile insurance*
- Court judgments and settlements*
- Long term care insurance

*These third party payers (and others) may **not** be listed on the client's eligibility verification.

Providers should use the same procedures for locating third party sources for Medicaid clients as for their non-Medicaid clients. Providers cannot refuse service because of a third party payer or potential third party payer.

## When a Client Has Medicare

Medicare claims are processed and paid differently than other non-Medicaid claims. The other sources of coverage are called "third party liability", but Medicare is not.

### *Medicare claims*

Medicare Part A covers hospice services. Any claims for services covered by Medicare must be submitted to Medicare before submitting to Medicaid. After Medicare processes the claim, an Explanation of Medicare Benefits (EOMB) is sent to the provider, and the provider can then bill Medicaid.

When the provider knows Medicare will not cover services at a particular time, the claim does not need to be submitted to Medicare first. Providers may submit the claim directly to Medicaid and certify that Medicare is not covering the service by writing "*Force Exc. 261 - Hospice Room & Board*" in form locator (FL) 84 of the UB-92 claim form. This exact wording must be used and written in dark ink, or the claim will be denied.

When submitting electronic claims with paper attachments, see the *Billing Electronically with Paper Attachments* section of the *Submitting a Claim* chapter.

When submitting a claim with the Medicare EOMB, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must also include the Medicaid provider number and Medicaid client ID number.

## When a Client Has TPL (ARM 37.85.407)

When a Medicaid client has additional medical coverage (other than Medicare), it is often referred to as third party liability or TPL. In most cases, providers must bill other insurance carriers before billing Medicaid.

Providers are required to notify their clients that any funds the client receives from third party payers (when the services were billed to Medicaid) must be turned over to the Department. The following words printed on the client's statement will fulfill this obligation, "When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid."

### *Exceptions to billing third party first*

When a Medicaid client is also covered by Indian Health Services (IHS), providers must bill Medicaid first. IHS is not considered a third party liability.

If the third party has only potential liability, such as automobile insurance, the provider may bill Medicaid first. Do not indicate the potential third party on the claim. Instead, notify the Department of the potential third party by sending notification to the Third Party Liability Unit (see *Key Contacts*).

### *Requesting an Exemption*

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information should be sent directly to the Third Party Liability Unit (see *Key Contacts*).

- When a provider is unable to obtain a valid assignment of benefits, the provider should submit the claim with documentation that the provider attempted to obtain assignment and certification that the attempt was unsuccessful.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation.
- If another insurance has been billed, and 90 days have passed with no response, submit the claim with a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company). Include the date the claim was submitted to the insurance company and certification that there has been no response.

### *When the Third Party Pays or Denies a Service*

When a third party payer is involved (excluding Medicare) and the other payer:

- Pays the claim, indicate the amount paid when submitting the claim to Medicaid for processing.
- Allows the claim, and the allowed amount went toward client's deductible, include the insurance Explanation of Benefits (EOB) when billing Medicaid.
- Denies the claim, submit the claim and a copy of the denial (including the reason explanation) to Medicaid.
- Denies a line on the claim, bill the denied lines together on a separate claim and submit to Medicaid. Include the explanation of benefits (EOB) from the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

### *When the Third Party Does Not Respond*

If another insurance has been billed, and 90 days have passed with no response, bill Medicaid as follows:

- Submit the claim and a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company).
- Include the date the claim was submitted to the insurance company.
- Send this information to the ACS Third Party Liability Unit (see *Key Contacts*).

If the provider receives a payment from a third party after the Department has paid the provider, the provider must return the lower of the two payments to the Department within 60 days.

# Billing Procedures

## Claim Forms

Services provided by the health care professionals covered in this manual must be billed either electronically or on a UB-92 claim form. UB-92 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

## Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within the latest of:

- Twelve months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- ***Medicare Claims:*** Six months from the date on the Medicare explanation of benefits approving the service (if the Medicare claim was timely filed and the client was eligible for Medicare at the time the Medicare claim was filed).
- ***Claims involving other third party payers (excluding Medicare):*** Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date that the claim was received by the Department or the claims processing contractor. All problems with claims must be resolved within this 12 month period.

### *Tips to avoid timely filing denials*

- Correct and resubmit denied claims promptly (see the *Remittance Advices and Adjustments* chapter in this manual).
- If a claim submitted to Medicaid does not appear on the remittance advice within 30 days, contact Provider Relations for claim status (see *Key Contacts*).
- If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid (see the *Coordination of Benefits* chapter in this manual for more information).
- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the *Coordination of Benefits* chapter in this manual.

## When To Bill Medicaid Clients (ARM 37.85.406)

In most circumstances, providers may not bill Medicaid clients for services covered under Medicaid.

If a provider bills Medicaid and the claim is denied because the client is not eligible, the provider may bill the client directly.

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a third-party payer does not respond.
- When services are provided by a hospice volunteer physician. Medicaid may not be billed for those services either.

## Client Cost Sharing

Hospice clients are exempt from Medicaid cost sharing. Providers may not charge for cost sharing on any services provided to the hospice client.

## When Clients Have Other Insurance

If a Medicaid client is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the client's health care, see the *Coordination of Benefits* chapter in this manual.

## Billing for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (Eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. For more information on retroactive eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

## Using the Medicaid Fee Schedule

When billing Medicaid, it is important to use the Department's fee schedule for your provider type. The hospice fee schedule is updated each October. Current fee schedules are available on the *Provider Information* web site (see *Key Contacts*). For disk or hardcopy, contact Provider Relations (see *Key Contacts*).

## Coding

Hospice services are billed with five revenue codes and various ICD-9-CM diagnosis codes. The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use current ICD-9-CM coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.

Always refer to the long descriptions in coding books.

## Billing For Hospice Services

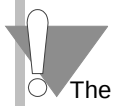
Medicaid pays the hospice for each day a client is under hospice care. The payment amounts, limits, and cap amounts are the same as in the Medicare program. The daily rate paid to hospices covers all services normally paid for by Medicare. Rates are set for routine home care, inpatient respite care, general in inpatient care, and continuous home care. Providers must bill for only one of these four fixed daily rates established by Medicare that include all services except for certain physician services and room and board for clients living in a long-term care facility. Please refer to the hospice fee schedule located on the *Provider Information web site* or available from Provider Relations (see *Key Contacts*).

### *Routine home care day*

This is a day in which the client is at home and is not receiving continuous home care during a crisis and is billed per day.

### *Continuous home care*

This is a day in which the client receives nursing services, home health, or homemaker services on a continuous basis during a period of crisis (see *Definitions*). The hospice must provide at least eight hours of nursing care per 24 hour period, which does not have to be continuous. Continuous care is billed using the hourly rate for the hours of service provided.



The Department will not pay a hospice for inpatient days (general and respite) that exceed 20% of the total hospice care days provided to a client.

### *Inpatient respite day*

This is a day in which the client receives inpatient care for respite. The hospice can bill for up to five consecutive days beginning with the day of admission, but excluding the day of discharge. Any respite care days beyond the five consecutive covered days must be billed as routine home care days.

### *General inpatient day*

This is a day in which the client receives general inpatient care in a hospital for control of pain or management of acute or chronic symptoms that can't be managed in the home. The hospice may bill for the date of admission, but not the date of discharge unless the client is discharged deceased.

### *Board and room for nursing facility residents*

For clients who reside in a nursing facility, the payment rate of the hospice board and room in a nursing facility is the Medicaid rate for that facility, less the client's personal resources applied to the cost of the room and board (and applicable disregards) as determined by the local Office of Public Assistance. This payment replaces the regular Medicaid payment for long-term care while the person receives hospice care. The hospice must instruct the nursing facility to bill the hospice rather than Medicaid. The hospice bills Medicaid and pays the nursing facility for these services.

## Billing For Physician Services

The client's attending physician, whether employed by the hospice or not, may be paid separately. These payment amounts are not included in the hospice cap amount. Payment for these services is the Medicaid rate for physician services. Physicians must use the *Physician Related Services* manual when billing Medicaid. Manuals are available on the *Provider Information web site* or from Provider Relations (see *Key Contacts*).

## Hospice Cap

The hospice may be paid for up to the current established Medicare cap amount on hospice care for a client. Hospice physician services are included in the cap amount. Room and board payments to a long-term care facility and certain payments to the client's attending physician (according to Medicare criteria) are not considered when the cap amount is calculated.

## The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many others are denied. To avoid returns and denials, double check each claim form to confirm the following items are included and accurate.

**Common Billing Errors**

| Reasons for Return | How to Prevent Returned Claims |
|---|---|
| Medicaid provider number missing or invalid | The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the billing form. |
| Authorized signature missing | Each claim form must have an authorized signature belonging to the provider, billing clerks, or office personnel. The signature may be typed, stamped, computer generated, or hand-written. |
| Signature date missing | Each form must have a signature date. |
| Incorrect claim form used | Hospice services are billed either electronically or on a UB-92 claim form. |

## Common Billing Errors (continued)

| Reasons for Return | How to Prevent Returned Claims |
|---|---|
| Information on claim form not legible | Information on the claim form should be legible. Use dark ink and center the information in the field – information should not be obscured by lines. |
| Recipient number not on file, or recipient was not eligible on date of service | Before providing services to the client, verify client eligibility by using one of the methods described in the *General Information For Providers* manual, *Client Eligibility and Responsibilities* chapter. |
| Duplicate claim | • Please check all remittance advices for previously submitted claims before resubmitting.<br>• When making changes to previously paid claims, submit an adjustment form rather than a new claim form (see *Remittance Advices and Adjustments*). |
| TPL on file and no credit amount on claim | • If the client has any other insurance (or Medicare), bill the other carrier before Medicaid, or the claim must be certified by the provider (see the *Coordination of Benefits* chapter in this manual).<br>• If the client's TPL coverage has changed, providers must notify the TPL unit (see *Key Contacts*) before submitting a claim. |
| Claim past 365-day filing limit | • The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in the *Billing Procedures* chapter.<br>• To ensure timely processing, paper claims and adjustments should be mailed to Claims Processing at the address shown in *Key Contacts*. |
| Missing Medicare EOMB | When Medicare is involved in payment on a claim, it must have an EOMB attached or be certified by the provider (see the *Coordination of Benefits* chapter in this manual). |
| Provider is not eligible during dates of services, or provider number terminated | • Out-of-state providers must update enrollment early to avoid denials. If enrollment has lapsed, claims submitted with a date of service after the expiration date will be denied.<br>• New providers cannot bill for services provided before Medicaid enrollment begins.<br>• If a provider requests to be terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied. |
| Type of service/procedure is not allowed for provider type | • Provider is not allowed to perform the service, or type of service is invalid.<br>• Check the Medicaid fee schedule to verify the procedure code is valid for your provider type. |
| Date of service later than date of death | • Check that both the correct dates of service and number of days were billed |
| Line level date of service missing | The date of service must be recorded in FL45 and must fall within the *Statement covers period* shown in FL6. |

# Submitting a Claim

## Electronic Claims

Professional and institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ***ACS field software WINASAP 2003.*** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded directly from the ACS EDI Gateway website. For more information on WINASAP 2003, visit the ACS EDI Gateway website, or call the number listed in the *Key Contacts* section of this manual.
- ***ACS clearinghouse.*** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway. For more information on using the ACS clearinghouse, contact ACS EDI Gateway (see *Key Contacts*).
- ***Clearinghouse.*** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway.

Providers should be familiar with the *Implementation Guides* that describe federal rules and regulations and provide instructions on preparing electronic transactions. These guides are available from the Washington Publishing Company (see *Key Contacts*). *Companion Guides* are used in conjunction with *Implementation Guides* and provide Montana-specific information for sending and receiving electronic transactions. They are available on the ACS EDI Gateway website (see *Key Contacts*).

## Billing Electronically with Paper Attachments

When submitting electronic claims that require additional supporting documentation, the *Attachment Control Number* field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Medicaid ID number followed by the client's ID number and the date of service, each separated by a dash:

| **9999999** | - | **888888888** | - | **11182003** |
|---|---|---|---|---|
| Medicaid Provider ID | | Client ID Number | | Date of Service (mmddyyyy) |

The supporting documentation must be submitted with a paperwork attachment cover sheet (located on the Provider Information website and in *Appendix A*). The number in the paper *Attachment Control Number* field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the *Companion Guides* located on the ACS EDI website (see *Key Contacts*).

## Paper Claims

The services described in this manual are billed on UB-92 claim forms. Claims submitted with all of the necessary information are referred to as "clean" and are usually paid in a timely manner (see the *Billing Procedure*s chapter in this manual).

When completing a claim, remember the following:

- Please use this information together with the UB-92 Reference Manual.
- All form locators shown in this chapter are required.
- Providers bill Medicaid for hospice services using the following revenue codes:

**Revenue Codes**

| Code | Description |
|---|---|
| 651 | Routine Home Care |
| 652 | Continuous Home Care |
| 655 | Inpatient Respite Care |
| 656 | General Inpatient Care |
| 659 | Nursing Facility Rate (Hospice Room and Board) |

# Completing a UB-92 Claim Form

| FL | Form Locator Title | Instructions |
|---|---|---|
| 1-2 | Unlabeled fields | Enter the hospice agency name, address, and phone number |
| 4 | Type of Bill | Use 81X for non-hospital based and 82X for hospital based hospice services. Only values of 81X and 82 X will be accepted. For more information, see the UB-92 Reference manual. |
| 6 | Statement covers period | Enter the beginning and ending dates of service. |
| 12 | Patient Name | Medicaid client's last name, first name, and middle initial |
| 22 | Patient Status | If the client has been discharged to an inpatient care facility, enter "04", otherwise leave blank. |
| 42 | Revenue Codes | Enter the appropriate revenue code (see *Revenue Code* table on the previous page). |
| 43 | Description | Revenue code description (see *Revenue Code* table on the previous page) |
| 45 | Serv. Date | Date of service (must be within *Statement covers period* shown in FL6) |
| 46 | Serv. Units | Number of services (or days) |
| 47 | Total Charges | Enter the sum of all charges for this service. |
| 50* | Payer | When a client receives hospice care in a nursing facility, enter the client's name. |
| 51 | Provider Number | Hospice provider's seven-digit Medicaid ID number |
| 54* | Prior Payments | When a client receives hospice care in a nursing facility, enter the clients personal resources. |
| 60 | Cert. - SSN - HIC - ID. No. | Enter the client's Medicaid ID number as it appears on the client's ID card. It is nine digits long and is usually the client's social security number. |
| 67-75 | Principal Diagnosis Code | Record the appropriate ICD-9-CM diagnosis code. At least one code is required for payment, and additional codes may be reported in FL 68 - 75. |
| 82 | Attending Physician ID | Enter the name and license number (or UPIN number) of the attending physician. |
| 84 | Remarks | When the client has Medicare and Medicaid, and Medicare denied the claim, enter "**Force Exc. 261 - Hospice Room & Board**". This statement must be written in FL 84 exactly as shown here, or the claim will be denied. |
| 85 | Provider Representative | The signature of the individual authorized to represent the hospice, which may be hand-written, typed, stamped, or computer generated. |
| 86 | Date | Enter the billing or signature date in MMDDYY format. This date must be on or after the last date of service reported in FL 6 of the claim, or it will be denied. |

* These two fields are required when billing for a client who receives hospice services in a nursing facility.

# Sample UB-92 Claim

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Hospice Care Center<br>123 Medical Drive<br>Anytown, MT 59999 | (406) 555-5555 | 3 PATIENT CONTROL NO. | 4 TYPE OF BILL<br>81X |

| 5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM | THROUGH | 7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11 |
|---|---|---|---|---|---|---|---|
| | 02/01/04 | 02/29/04 | | | | | |

| 12 PATIENT NAME | 13 PATIENT ADDRESS |
|---|---|
| Rose Floweree | |

| 14 BIRTHDATE | 15 SEX | 16 MS | ADMISSION 17 DATE | 18 HR | 19 TYPE | 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO. | CONDITION CODES 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | |

| 32 CODE / OCCURRENCE DATE | 33 CODE / OCCURRENCE DATE | 34 CODE / OCCURRENCE DATE | 35 CODE / OCCURRENCE DATE | 36 CODE / OCCURRENCE SPAN FROM / THROUGH | 37 |
|---|---|---|---|---|---|
| a | | | | | A |
| b | | | | | B |
| | | | | | C |

38

| 39 VALUE CODES CODE / AMOUNT | 40 VALUE CODES CODE / AMOUNT | 41 VALUE CODES CODE / AMOUNT |
|---|---|---|
| a | | |
| b | | |
| c | | |
| d | | |

| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATES | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|
| 1 651 | Routine Home Care | | 02/15/04 | 15 | 1,725.00 | | 1 |
| 2 652 | Continuous Home Care | | 02/29/04 | 8 | 224.00 | | 2 |
| 3 | | | | | | | 3 |
| 4 | | | | | 1,949.00 | | 4 |
| 5 | | | | | | | 5 |
| 6 | | | | | | | 6 |
| 7 | | | | | | | 7 |
| 8 | | | | | | | 8 |
| 9 | | | | | | | 9 |
| 10 | | | | | | | 10 |
| 11 | | | | | | | 11 |
| 12 | | | | | | | 12 |
| 13 | | | | | | | 13 |
| 14 | | | | | | | 14 |
| 15 | | | | | | | 15 |
| 16 | | | | | | | 16 |
| 17 | | | | | | | 17 |
| 18 | | | | | | | 18 |
| 19 | | | | | | | 19 |
| 20 | | | | | | | 20 |
| 21 | | | | | | | 21 |
| 22 | | | | | | | 22 |
| 23 | | | | | | | 23 |

| 50 PAYER | 51 PROVIDER NO. | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 |
|---|---|---|---|---|---|---|
| A | 9999999 | | | | | |
| B | | | | | | |
| C | | | | | | |
| 57 | DUE FROM PATIENT ▶ | | | | | |

| 58 INSURED'S NAME | 59 P. REL | 60 CERT. - SSN - HIC. - ID NO. | 61 GROUP NAME | 62 INSURANCE GROUP NO. |
|---|---|---|---|---|
| A | | 99999999 | | |
| B | | | | |
| C | | | | |

| 63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION |
|---|---|---|---|
| A | | | |
| B | | | |
| C | | | |

| 67 PRIN. DIAG. CD. | OTHER DIAG. CODES 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 ADM. DIAG. CD. | 77 E-CODE | 78 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 154.1 | | | | | | | | | | | |

| 79 P.C. | 80 PRINCIPAL PROCEDURE CODE / DATE | 81 OTHER PROCEDURE CODE / DATE | OTHER PROCEDURE CODE / DATE | 82 ATTENDING PHYS. ID |
|---|---|---|---|---|
| | | A | B | D99999 |

| OTHER PROCEDURE CODE / DATE | OTHER PROCEDURE CODE / DATE | OTHER PROCEDURE CODE / DATE | 83 OTHER PHYS. ID |
|---|---|---|---|
| C | D | E | a A |
| | | | b |
| | | | OTHER PHYS. ID |
| | | | a B |
| | | | b |

| a 84 REMARKS | 85 PROVIDER REPRESENTATIVE | 86 DATE |
|---|---|---|
| b | X Betty Biller | 03/01/04 |
| c | | |
| d | | |

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

## Mailing Paper Claims

Unless otherwise stated, all paper claims are mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

All Medicaid claims must be submitted on Department approved claim forms. UB-92 forms are available through various publishing companies; they are not available from the Department or Provider Relations. A *Medicaid Form Order* sheet is available under the *Forms* section of the Provider Information website.

## Claim Inquiries

Claim inquiries can be obtained electronically through ANSI ASC X12N 276/277 transactions or by contacting Provider Relations. See the *Companion Guides* located on the ACS EDI Gateway website for more information on electronic transactions (see *Key Contacts*). Providers may contact Provider Relations for questions regarding payments, denials, and other claim questions (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A.* Complete the top portion of the form with the provider's name and address.

Provider Relations will respond to the inquiry within 7 to 10 days. The response includes the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

## Avoiding Claim Errors

Claims are often denied or even returned to the provider before they can be processed. To avoid denials and returns, double check each claim form to confirm the following items are accurate. For more information on returned and denied claims, see the *Billing Procedures* chapter in this manual.

## Common Claim Errors

| Claim Error | Prevention |
|---|---|
| Required field is blank | All fields shown in the *Completing a UB-92 Claim Form* section in this chapter must be complete. If any of these fields are blank, the claim may either be returned or denied. |
| Client ID number missing or invalid | This is a required field (FL60); verify that the client's Medicaid ID number is listed as it appears on the client's ID card. |
| Client name missing | This is a required field (FL12); check that it is correct. |
| Medicaid provider number missing or invalid | The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim (FL51). |
| Authorized signature missing | Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, computer generated, or handwritten. |
| Signature date missing | Each claim must have a signature date. |
| Incorrect claim form used | When billing on paper, services covered in this manual require a UB-92 claim form. |
| Information on claim form not legible | Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines. |
| Missing Medicare EOMB | When Medicare is involved in payment on a claim, it must have an EOMB attached or be certified by the provider (see the *Coordination of Benefits* chapter in this manual). |
| Line level date of service missing | The date of service must be recorded in FL45 and must fall within the *Statement covers period* shown in FL6. |

MONTANA
Department of Public Health & Human Services

# Remittance Advices and Adjustments

## The Remittance Advice

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous RA cycle. Providers may select a one or two week payment cycle (see *Payment and the RA* in this chapter). Each line of the RA represents all or part of a claim, and explains whether the claim or line has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

### *Electronic RA*

Providers may receive the RA electronically as an ANSI ASC X12N 835 transaction, or through the Internet on the Montana Eligibility and Payment System (MEPS). For more information on 835 transactions, see the *Companion Guides* available on the ACS EDI Gateway website and the *Implementation Guides* on the Washington Publishing Company website (see *Key Contacts*).

MEPS is available through the Virtual Human Services Pavilion (see *Key Contacts*). In order to access MEPS, you must complete an *Access Request Form*. After this form has been processed, you will receive a password. Entry into the system requires a valid provider or group number and password. Each provider or group number requires a unique password, so providers must complete a separate request form for each provider or group.

RAs are available from MEPS in PDF and a flat file format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the "SOR Download" page. The file layout for flat files is also available on the SOR download page. Due to space limitations, each RA is only available for six weeks. For more information on MEPS, see *Payment and the RA* later in this chapter.

### *Paper RA*

The paper RA is divided into the following sections: RA notice, paid claims, denied claims, pending claims, credit balance claims, gross adjustments, and reason and remark codes and descriptions. See the following sample paper RA and the *Keys to the Paper RA* table.

Electronic RAs are available for only six weeks on MEPS.

If a claim was denied, read the reason and remark code description before taking any action on the claim.

The pending claims section of the RA is informational only. Do not take any action on claims shown here.

## Sections of the Paper RA

| Section | Description |
|---|---|
| **RA notice** | The RA Notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims. |
| **Paid claims** | This section shows claims paid and any claims paid with denied lines during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see *Adjustments* later in this chapter). |
| **Denied claims** | This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See *The Most Common Billing Errors and How to Avoid Them* in the *Billing Procedures* chapter. |
| **Pending claims** | All claims that have not reached final disposition will appear in this area of the RA. The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/ Remark Code column (Field 16). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied.<br><br>Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number. |
| **Credit balance claims** | Credit balance claims are shown here until the credit has been satisfied. |
| **Gross adjustments** | Any gross adjustments performed during the previous cycle are shown here. |
| **Reason and Remark Code Description** | This section lists the reason and remark codes that appear throughout the RA with a brief description of each. |

# Sample Paper Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604

MEDICAID REMITTANCE ADVICE

(1)

HOSPICE CARE SERVICES
123 MEDICAL DRIVE
ANYTOWN MT 59999

(2) PROVIDER# 0001234567 (3) REMIT ADVICE #123456 (4) WARRANT # 123456 (5) DATE:02/04/04 PAGE 2 (6)

| RECIP ID (7) | NAME (8) | SERVICE DATES FROM | TO (10) | UNIT OF SVC (11) | PROCEDURE REVENUE NDC (12) | TOTAL CHARGES (13) | ALLOWED (14) | CO-PAY (15) | REASON/ REMARK CODES (16) |
|---|---|---|---|---|---|---|---|---|---|
| **PAID CLAIMS - NURSING HOME CLAIMS** | | | | | | | | | |
| 123456789 | DOE, JOHN EDWARD | 011704 | 013104 | 15 | 651 | 1725.00 | | | |
| (9) ICN | 00403111123000700 | | | | | | | | |
| | ***LESS RECIPIENT PAYMENT****** | | | | | | 0.00 (17) | | |
| | ***CLAIM TOTAL********** | | | | | 1725.00 | 1572.90 | | |
| **DENIED CLAIMS - NURSING HOME CLAIMS** | | | | | | | | | |
| 123456790 | DOE, JOE EDWARD | 011704 | 013104 | 15 | 651 | 1725.00 | | | 31MA61 |
| ICN | 00403111123000800 | | | (16) | | | | | |
| **PENDING CLAIMS - NURSING HOME CLAIMS** | | | | | | | | | |
| 123456791 | DOE, JANE EDWINA | 011704 | 013104 | 15 | 651 | 1725.00 | | | 31 |
| ICN | 00403111123000900 | | | | | | | | |

**********THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE**********

31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.

MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

# Key to the Paper RA

| Field | Description |
|---|---|
| 1. Provider name and address | Provider's business name and address as recorded with the Department |
| 2. Provider number | The 7-digit number assigned to the provider when applying for Medicaid |
| 3. Remittance advice number | The remittance advice number |
| 4. Warrant number | Not used |
| 5. Date | The date the RA was issued |
| 6. Page Number | The page number of the RA |
| 7. Recipient ID | The client's Medicaid ID number |
| 8. Name | The client's name |
| 9. Internal control number (ICN) | Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information:<br>0 00111 11 123 000123<br>A B C D E<br>A = Claim medium<br>0 = Paper claim<br>2 = Electronic claim<br>3 = Encounter claim<br>4 = System generated claim (mass adjustment, nursing home turn-around document, or POS pharmacy claim)<br>B = Julian date (e.g. April 20, 2000 was the 111th day of 2000)<br>C = Microfilm number<br>00 = Electronic claim<br>11 = Paper claim<br>D = Batch number<br>E = Claim number<br>If the first number is:<br>0 = Regular claim<br>1 = Negative side adjustment claim (Medicaid recovers payment)<br>2 = Positive side adjustment claim (Medicaid reprocesses) |
| 10. Service dates | Date(s) services were provided. If service(s) were performed in a single day; the same date will appear in both columns |
| 11. Unit of service | The number of services rendered under this procedure or NDC code. |
| 12. Procedure/revenue/NDC | The procedure, revenue, HCPCS, or NDC billed will appear in this column. If a modifier was used, it will also appear in this column. |
| 13. Total charges | The amount a provider billed for this service. |
| 14. Allowed | The Medicaid allowed amount. |
| 15. Co-pay | Not applicable for nursing home residents. |
| 16. Reason/Remark Code | A code which explains why the specific service was denied or pended. Descriptions of these codes are listed at the end of the RA. |
| 17. Deductions, Billed Amount, and Paid Amount | Any deductions, such as personal resources or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement. |

### *Credit balance claims*

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

Credit balances can be resolved in two ways:

- By "working off" the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
- By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of the *Provider Relations Field Representative* at the Provider Relations address in *Key Contacts*.

The Credit Balance section is informational only. Do not post from credit balance statements.

## Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems providers may experience. Knowing when to use the rebilling process versus the adjustment process is important.

### *How long do I have to rebill or adjust a claim?*

- Providers may resubmit, modify, or adjust any initial claim within the timely filing limits described in the *Billing* chapter.
- The time periods do not apply to overpayments that the provider must refund to the Department. After the 12 month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check, or request Provider Relations to complete a gross adjustment.

Medicaid does not accept any claim for resubmission, or adjustment after 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter.)

### *Rebilling Medicaid*

Rebilling is when a provider submits a claim to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* chapter in this manual.

### *When to rebill Medicaid*

- ***Claim Denied.*** Providers may rebill Medicaid when a claim is denied. Check the reason and remark codes, make the appropriate corrections and resubmit the claim (do not use the adjustment form).

Rebill denied claims only after appropriate corrections have been made.

- ***Claim Returned.*** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit the claim.

### How to rebill

- Check any reason and remark code listed and make corrections on a copy of the claim, or produce a new claim with the correct information.
- When making corrections on a copy of the claim, remember to line out or omit all lines that have already been paid.
- Submit insurance information with the corrected claim.

### Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see *Billing Procedures, Claim Inquiry*). Once an incorrect payment has been verified, the provider should submit an *Individual Adjustment Request* form (in *Appendix A*), to Provider Relations. If incorrect payment was the result of an ACS keying error, contact Provider Relations.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12$^{th}$ digit over will be a 2, indicating an adjustment. See the *Key to the Paper RA* earlier in this chapter. Adjustments are processed in the same time frame as claims.

### When to request an adjustment

- Request an adjustment when an individual line is denied on a multiple-line UB-92 claim. The denied service must be submitted as an adjustment rather than a rebill.
- Request an adjustment when the claim was overpaid or underpaid.
- Request and adjustment when the claim was paid but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).

### How to request an adjustment

To request an adjustment, use the *Montana Medicaid Individual Adjustment Request* form in *Appendix A*. The requirements for adjusting a claim are as follows:

- Adjustments can only be submitted on paid claims; denied claims cannot be adjusted.
- Claims Processing must receive individual claim adjustments within 12 months from the date of service (see *Timely Filing* in the *Billing Procedures* chapter of this manual). After this time, *gross adjustments* are required (see *Definitions*).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section.

### Completing an Adjustment Request Form

1. Copy the *Montana Medicaid Individual Adjustment Request* form from *Appendix A*, or download it from the Provider Information website. Complete *Section A* first with provider and client information and the claim's ICN number (see following table).
2. Complete *Section B* with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
    - Enter the date of service or the line number in the *Date of Service or Line Number* column.
    - Enter the information from the claim form that was incorrect in the *Information on Statement* column.
    - Enter the correct information in the column labeled *Corrected Information*.
3. Attach copies of the RA and a corrected claim if necessary.
    - If the original claim was billed electronically, a copy of the RA will suffice.
    - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing (see *Key Contacts*).

## Completing an Individual Adjustment Request Form

| Field | Description |
|---|---|
| **Section A** | |
| 1. Provider Name and Address | Provider's name and address (and mailing address if different). |
| 2. Recipient Name | The client's name is here. |
| 3.* Internal Control Number (ICN) | There can be only one ICN per Adjustment Request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim. |
| 4.* Provider number | The provider's Medicaid ID number. |
| 5.* Recipient Medicaid Number | Client's Medicaid ID number. |
| 6. Date of Payment | Date claim was paid found on Remittance Advice Field #5 (see the sample RA earlier in this chapter). |
| 7. Amount of Payment | The amount of payment from the Remittance Advice Field #17 (see the sample RA earlier in this chapter.). |
| **Section B** | |
| 1. Units of Service | If a payment error was caused by an incorrect number of units, complete this line. |
| 2. Procedure Code/ N.D.C/ Revenue Code | If the procedure code, NDC, or revenue code are incorrect, complete this line. |
| 3. Dates of Service (D.O.S) | If the date(s) of service is incorrect, complete this line. |
| 4. Billed Amount | If the billed amount is incorrect, complete this line. |
| 5. Personal Resource (Nursing Home) | If the client's personal resource amount is incorrect, complete this line. |
| 6. Insurance Credit Amount | If the client's insurance credit amount is incorrect, complete this line. |
| 7. Net (Billed – TPL or Medicare Paid) | If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount TPL or Medicare paid. |
| 8. Other/Remarks | If none of the above items apply, or if you are unsure what caused the payment error, complete this line. |

* Indicates a required field

- If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
- If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount from the provider. This can be done in two ways, by the provider issuing a check to the Department, or by maintaining a credit balance until it has been satisfied with future claims (see *Credit Balance* earlier in this chapter).
- Any questions regarding claims or adjustments should be directed to Provider Relations (see *Key Contacts*).

### *Mass adjustments*

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments on the first page of the remittance advice (RA Notice section), the monthly Claim Jumper, or provider notice. Mass adjustment claims shown on the RA have an ICN that begins with a "4" (see *Key Fields on the Remittance Advice* earlier in this chapter).

## Payment and The RA

Weekly payments are available only to providers who receive both EFT **and** electronic RAs.

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A) (see the following table). One form must be completed for each provider number.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. For questions or changes regarding EFT, contact the Technical Services Center and ask for the Medicaid Direct Deposit Manager (see *Key Contacts*).

## Required Forms For EFT and/or Electronic RA

**All three forms are required for a provider to receive weekly payment**

| Form | Purpose | Where to Get | Where to Send |
|---|---|---|---|
| Electronic Remittance Advice and Payment Cycle Enrollment Form | Allows provider to receive electronic remittance advices on MEPS (must also include MEPS Access Request form) | • Provider Information website<br>• Provider Relations (see *Key Contacts*) | Provider Relations (see *Key Contacts*) |
| Direct Deposit Sign-up Form Standard Form 1199A | Allows the Department to automatically deposit Medicaid payment into provider's bank account | • Provider Information website (see *Key Contacts*)<br>• Provider's bank | Provider Relations (see *Key Contacts*) |
| MEPS Access Request Form | Allows provider to receive a password to access their RA on MEPS | • Provider Information website<br>• Virtual Human Services Pavilion<br>• Direct Deposit Manager of the DPHHS Technical Services Center<br>(see *Key Contacts)* | DPHHS address on the form |

MONTANA
Department of Public Health & Human Services

# How Payment Is Calculated

## Overview

Though providers do not need the information in this chapter in order to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims.

## Hospice Rates

The Centers for Medicare and Medicaid (CMS) establishes rates for each category of service:

- Routine home care
- Continuous home care
- Inpatient respite care
- General inpatient care

CMS updates hospice care rates annually. They issue a hospice wage index based on the most current available CMS hospital wage data. Medicaid uses the wage index to adjust rates to reflect local differences in wages for different areas of Montana. The following table is an example of hospice rates for Montana as of October, 2003 and may not apply to all areas of Montana and at other times.

**Montana Hospice Rates**
October 1, 2003 to September 30, 2004

| Service | Wage | Index | Indexed | Unweighted | Total |
|---|---|---|---|---|---|
| Routine home care | $ 81.24 | 0.9 | $ 73.12 | $ 36.99 | $ 110.11 |
| Continuous home care | 473.72 | 0.9 | 426.35 | 215.73 | 642.08/24<br>26.75 |
| Inpatient respite care | 69.60 | 0.9 | 62.64 | 58.98 | 121.62 |
| General inpatient care | 336.23 | 0.9 | 302.61 | 189.05 | 491.66 |

### *Calculating rates*

Hospice rates are calculated annually using the following method. The wage adjusted reimbursement for routine home care is calculated by multiplying the wage component subject to the index ($81.24) by the index rate (0.9) for a rate of $73.12. The wage adjusted rate ($73.12) is then added to the unweighted rate (the wage amount not subject to a wage adjustment) of $36.99 for a total

Many Medicaid payment methods are based on Medicare, but there are differences. In these cases, the Medicaid method prevails.

routine home care rate of $110.11. This method is followed for each category of service. For continuous home care, the total is then divided by 24 to get the hourly rate of $26.75.

### *Calculating payment*

Providers can estimate the payment received by Medicaid using the following method. In this example, a hospice provides a client with 23 days of routine home care, one five day period of respite care, general inpatient care for three days and 10 hours of continuous home care for one day. To calculate the payment the hospice will receive for this client, multiply the days/hours by the rate for each category of service and total the amounts for a payment of $4,883.11, less any applicable fees (e.g., incurment, etc.).

**Sample Payment Calculation for Hospice Client**

| Service | Days or Hours | Rate | Total |
|---|---|---|---|
| Routine home care | 23 | $110.11 | $2,532.53 |
| Inpatient respite care | 5 | 121.62 | 608.10 |
| General inpatient care | 3 | 491.66 | 1,474.98 |
| Continuous home care | 10 | 26.75 | 267.50 |
| | | | $4,883.11 |

## Caps

Payment for hospice care is subject to an inpatient cap amount and an overall cap amount. Cap periods are calculated from November 1 through October 31. The same cap amounts that apply to Medicare also apply to Medicaid. These examples are from March, 2004 and may not apply at other times.

### *Inpatient cap*

A hospice's aggregate total inpatient care days (general and respite) during a cap year (November 1 - October 31) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid clients during that same period. At the end of the cap period, the total number of Medicaid hospice days is multiplied by 0.2. If the total number of days of inpatient care furnished to Medicaid hospice clients is less than or equal to this number, no adjustment is necessary. If the inpatient care days exceeds this number, the hospice payment during the previous twelve months is calculated to determine if the payment amount is in excess of the amount that should have been reimbursed. If it is, the hospice will have to refund the excess amount.

### *Overall cap*

Overall aggregate payments made to a hospice are subject to a cap amount received by the end of the hospice cap period. The cap period runs from November 1st of each year through October 31 of the next year. The total pay-

ment made for services furnished to Medicaid clients during this period are compared to the cap amount for this period. Any payment in excess of the cap must be refunded by the hospice.

A hospice can calculate the total amount of payment it should have received during a cap year by multiplying the number of Medicaid clients electing hospice care during the period by the cap amount. For example, for services provided from November 1, 2001 to October 21, 2002, the cap amount is $18,661.29. A hospice receives $2,408,894.83 from Medicaid during the cap year. The hospice had 129 Medicaid clients. Multiply 129 by 18,661.29. The hospice should not have received more than $2,407,306.41. The provider must return $1,588.42.

When determining the number of Medicaid clients who have elected hospice care during the period, providers must consider both of the following:

- The client must not have been counted previously in either another hospice's cap or another reporting year
- The client must file an initial election during the period beginning September 28 of the previous cap year through September 27 of the current cap year to be counted as an electing Medicaid client during the current cap year. This slight adjustment is necessary to produce a reasonable estimate of the proportionate number of clients to be counted in each cap period.

# Appendix A

- ***Physician's Certification for Medicaid Hospice Benefit***
- ***Patient Election for Medicaid Hospice Services by Hospice and Assignment Benefits***
- ***Paperwork Attachment Cover Sheet***
- ***Montana Medicaid Claim Inquiry Form***
- ***Montana Medicaid Individual Adjustment Request***

**PHYSICIAN'S CERTIFICATION FOR MEDICAID HOSPICE BENEFIT**

Physician Certification of Terminal Illness
for Hospice Medicaid Benefit

**A. Certification Statement for First 90-Day Period**

I (or we) certify that _____, is terminally ill with a life expectancy of six months or less. (Patient's name)

_____ _____
(Date by Physician) (Hospice Medical Director or Physician Signature)

_____ _____
(Date by Physician) (Attending Physician Signature)

**B. Recertification Statement Second 90-Day Period**

I recertify that the above patient is still considered terminally ill with a life expectancy of six months or less.

_____ _____
(Date by Physician) (Hospice Medical Director or Physician Signature)

**C. Recertification Statement for 60-Day Period**

I recertify that the above patient is still considered terminally ill with a life expectancy of six months or less.

_____ _____
(Date by Physician) (Hospice Medical Director or Physician Signature)

**D. Recertification Statement for 60 day Period**

I recertify that the above patient is still considered terminally ill with a life expectancy of six months or less.

_____ _____
(Date by Physician) (Hospice Medical Director or Physician Signature)

**PATIENT ELECTION FOR MEDICAID HOSPICE SERVICES BY HOSPICE AND ASSIGNMENT BENEFITS**

The undersigned patient hereby elects to receive Medicaid hospice care in lieu of other Medicaid benefits (except attending physician, Medicaid Services not covered by Medicare and room and board in a nursing facility) related to treatment of the condition certified by the attending physician of the undersigned.

I have read and understand the description of service to be provided by _____ Hospice.

I understand that Hospice cannot provide 24-hour care in my home to take the place of family members or friends. Should it become necessary for me to have a "live-in" helper, I will need to use my own resources to pay that person or consider nursing home care.

I further understand that in making this election, I waive all other rights to Medicaid benefits as to the certified condition, except for the services of my attending physician, Medicaid Services not covered by Medicare and room and board in a nursing facility.

I further understand that I am entitled to four election periods of hospice care consisting of two ninety-day periods, and unlimited sixty-day periods.

I understand that I may revoke this election of hospice care at anytime by filing a revocation statement with _____ Hospice. If I revoke the benefit, I also revoke the remaining days of that benefit period.

In consideration of the foregoing, I agree to accept the services of and hereby assign my Medicaid hospice benefits to _____ Hospice.

Dated at_____ this __ day of _____, 20 _____.

_____ Patient Signature

_____ Witness Signature

_____ Patient Birthdate

_____ Patient Name (type or print)

_____ Age

_____ Address

_____ Medicaid ID#

_____ City State Zip

MONTANA
Department of Public Health & Human Services

# Paperwork Attachment Cover Sheet

**Paperwork Attachment Control Number:** _____

**Date of service:** _____

**Medicaid provider number:** _____

**Medicaid client ID number:** _____

**Type of attachment:** _____

## Instructions:

This form is used as a cover sheet for attachments to electronic claims sent to Montana Medicaid. The *Paperwork Attachment Control Number* must be the same number as the *Attachment Control Number* on the corresponding electronic claim. This number should consist of the provider's Medicaid ID number, the client's Medicaid ID number and the date of service (mmddyyyy), each separated by a dash (9999999-999999999-99999999). This form may be copied or downloaded from our website www.mtmedicaid.org. If you have questions about which paper attachments are necessary for a claim to process, please call Provider Relations at (406) 442-1837 or (800) 624-3958.

# Montana Medicaid Claim Inquiry Form

Provider Name _____
Contact Person _____
Address _____
Date _____
Phone Number _____
Fax Number _____


For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

| | |
|---|---|
| Provider number _____<br>Client number _____<br>Date of service _____<br>Total billed amount _____<br>Date submitted for processing _____ | ACS Response: _____ |
| Provider number _____<br>Client number _____<br>Date of service _____<br>Total billed amount _____<br>Date submitted for processing _____ | ACS Response: _____ |
| Provider number _____<br>Client number _____<br>Date of service _____<br>Total billed amount _____<br>Date submitted for processing _____ | ACS Response: _____ |

**Mail to:** Provider Relations
P.O. Box 8000
Helena, MT 59604

**Fax to:** (406) 442-4402

# MONTANA MEDICAID/MHSP/CHIP
# INDIVIDUAL ADJUSTMENT REQUEST

**INSTRUCTIONS:**

**This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).**

## A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

**1. PROVIDER NAME & ADDRESS**

_____
**Name**

_____
**Street or P.O. Box**

_____
**City** **State** **Zip**

**2. CLIENT NAME**

_____

**3. INTERNAL CONTROL NUMBER (ICN)**

_____

**4. PROVIDER NUMBER**

_____

**5. CLIENT ID NUMBER**

_____

**6. DATE OF PAYMENT** _____

**7. AMOUNT OF PAYMENT $** _____

## B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

| | DATE OF SERVICE OR LINE NUMBER | INFORMATION STATEMENT | CORRECTED INFORMATION |
|---|---|---|---|
| 1. Units of Service | | | |
| 2 Procedure Code/N.D.C./Revenue Code | | | |
| 3. Dates of Service (D.O.S.) | | | |
| 4. Billed Amount | | | |
| 5. Personal Resource (Nursing Home) | | | |
| 6. Insurance Credit Amount | | | |
| 7. Net (Billed - TPL or Medicare Paid) | | | |
| 8. Other/REMARKS (BE SPECIFIC) | | | |

**SIGNATURE:** _____ **DATE:** _____

**When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).**

**MAIL TO: Provider Relations**
**ACS**
**P.O. Box 8000**
**Helena, MT 59604**

# Definitions and Acronyms

**This section contains definitions, abbreviations, and acronyms used in this manual.**

### 270/271 Transactions
The ASC X12N eligibility inquiry (270) and response (271) transactions.

### 276/277 Transactions
The ASC X12N claim status request (276) and response (277) transactions.

### 278 Transactions
The ASC X12N request for services review and response used for prior authorization.

### 835 Transactions
The ASC X12N payment and remittance advice (explanation of benefits) transaction.

### 837 Transactions
The ASC X12N professional, institutional, and dental claim transactions (each with its own separate Implementation Guide).

### Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)
The ANSI-accredited standards development organization, and one of the six Designated Standards Maintenance Organizations (DSMO), that has created and is tasked to maintain the administrative and financial transactions standards adopted under HIPAA for all health plans, clearinghouses, and providers who use electronic transactions.

### Adjustment
When a claim has been incorrectly paid, the payment amount can be changed by submitting an adjustment request.

### Administrative Review
Administrative reviews are the Department's effort to resolve a grievance about a Department decision in order to avoid a hearing. The review includes an informal conference with the Department to review facts, legal authority, and circumstances involved in the adverse action by the Department.

### Administrative Rules of Montana (ARM)
The rules published by the executive departments and agencies of the state government.

### Administrator
The person licensed by the state as a nursing home or hospital administrator with daily responsibility for operation of the facility. This person may be someone other than the titled administrator of the facility.

### Assignment of Benefits
When a provider accepts the maximum allowable charge offered for a given procedure by the insurance company, it is said that the provider accepts assignment.

### Attending Physician
A doctor of medicine or osteopathy who is identified by the client at the time of election to receive hospice. The attending physician has the most significant role in the determination and delivery of the client's medical care and must be licensed to practice medicine in the state of Montana.

### Audit
A formal or periodic verification of accounts.

### Authorization
An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

### Bereavement Counseling
Counseling services provided to the family after the client's death.

### Cap Amount
The limit on overall hospice reimbursement, as established by Medicare.

### Carrier
A private insurance company.

### Centers for Medicare and Medicaid Services (CMS)
Administers the Medicare program and oversees the state Medicaid program. Formerly the Health Care Financing Administration (HCFA).

### Children's Health Insurance Plan (CHIP)
CHIP offers low-cost or free health insurance for low-income children younger than 19. Children must be uninsured US citizens or qualified aliens, Montana residents who are not eligible for Medicaid. DPHHS administers the program and purchases health insurance from BlueCross BlueShield (BCBS) of Montana. Benefits for dental services and eyeglasses are provided by DPHHS through the same contractor (ACS) that handles Medicaid provider relations and claims processing.

### Children's Special Health Services (CSHS)
CSHS provides assistance for children with special health care needs. CSHS assists in paying for medical expenses related to specific conditions, specialty clinics, and finding resources. Medicaid eligible children do not receive assistance with medical expenses from CSHS, but specialty clinics are open to all children with special health care needs. CSHS is funded by Title V, the Maternal and Child Health Block Grant.

### Claims Attachment
Supplemental information about the services provided to a client that supports medical or other evaluation for payment, post-payment review, or quality control requirements that are directly related to one or more specific services billed on the claim.

### Claims Clearinghouse
When a provider contracts with a clearinghouse, the clearinghouse supplies the provider with software that electronically transmits claims to the clearinghouse. The clearinghouse then transmits the claims to the appropriate payers.

### Clean Claim
A claim that can be processed without additional information or documentation from or action by the provider of the service.

### Client
An client enrolled in a Department medical assistance program.

### Coinsurance
The client's financial responsibility for a medical bill as assigned by Medicare. Medicare coinsurance is usually 20% of the Medicare allowed amount.

### Companion Guide
A document provided by some health plans to supplement or clarify information about HIPAA standard transactions (available on the ACS EDI Gateway website).

### Continuous Home Care
Nursing care provided in a period of crisis which will achieve palliation or management of acute medical symptoms. A minimum of eight hours of nursing care must be provided during a 24-hour day.

### Copayment
The client's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

### Cosmetic
Serving to modify or improve the appearance of a physical feature, defect, or irregularity.

### Cost sharing
The client's financial responsibility for a medical bill, usually in the form of a flat fee.

### CPT-4
Physicians' ***Current Procedural Terminology, Fourth Edition***. This book contains procedure codes which are used by medical practitioners in billing for services rendered. The book is published by the American Medical Association.

### Credit Balance Claims
Adjusted claims that reduce original payments, causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the remittance advice until the credit has been satisfied.

### Crisis Period
A period in which the client requires continuous care to achieve palliation or management of acute medical symptoms.

### Crossovers
Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

### DPHHS, State Agency
The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

### Dual Eligibles
Clients who are covered by Medicare and Medicaid are often referred to as "dual eligibles."

### Early & Periodic Screening, Diagnosis & Treatment (EPSDT) Program
This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

### Election Period
A period of time in which an eligible hospice client may elect to receive hospice care.

### Electronic Data Interchange (EDI)
The communication of information in a stream of data from one party's computer system to another party's computer system.

### Electronic Funds Transfer (EFT)
Payment of medical claims that are deposited directly to the provider's bank account.

### Emergency Services
Those services which are required to evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

### Employee
An employee of the hospice or, if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is appropriately trained and assigned to the hospice unit. Employee also includes a volunteer under the supervision of the hospice.

### Experimental
A non-covered item or service that researchers are studying to investigate how it affects health.

### Explanation of Benefits Codes (EOB)
A three digit code which prints on Medicaid remittance advice (RA) that explains why a claim was denied or suspended. The explanation of the EOB codes is found at the end of the RA.

### Explanation of Medicare Benefits (EOMB)
A notice sent to providers informing them of the services which have been paid by Medicare.

### Fair Hearing
Providers may request a fair hearing when the provider believes the Department's administrative review determination fails to comply with applicable laws, regulations, rules or policies. Fair hearings include a hearings officer, attorneys, and witnesses for both parties.

### Fiscal Agent
ACS is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.85 et seq.

### Full Medicaid
Clients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

### Gross Adjustment
These adjustments are done in a lump-sum payment or reduction without regard to individual claims.

### HCPCS
Acronym for the Healthcare Common Procedure Coding System, and is pronounced "hick-picks." There are three types of HCPCS codes:

- Level 1 includes the CPT-4 codes.
- Level 2 includes the alphanumeric codes A - V which CMS maintains for a wide range of services from ambulance trips to hearing aids which are not addressed by CPT-4 coding.
- Level 3 includes the alphanumeric codes W - Z which are assigned for use by state agencies (also known as local codes).

### Health Insurance Portability and Accountability Act (HIPAA)
A federal plan designed to improve efficiency of the health care system by establishing standards for transmission, storage, and handling of data.

### Home
The client's place of residence.

### Hospice
A program that provides health and support services to terminally ill clients and their families. Hospice care is an approach to treatment that, recognizing the impending death, focuses on palliative rather than curative care. The hospice seeks to help the client and those close to the person come to terms with the terminal condition and live the remaining life as fully as possible.

### Hospice Care
Hospice services provided by a hospice to a terminally ill person.

### ICD-9-CM
*The International Classification of Diseases, 9th Revision, Clinical Modification.* This is a three volume set of books which contains the diagnosis codes used in coding claims, as well as the procedure codes used in billing for services performed in a hospital setting.

### Implementation Guide (IG)
The official source of specifications with respect to how the HIPAA administrative and financial transactions are to be implemented (available on the Washington Publishing Company website).

### Incurment
The amount a Medicaid client has to pay for their medical services before Medicaid will pay for services. See *Coverage for the Medically Needy* in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.

### Indian Health Services (IHS)
IHS provides federal health services to American Indians and Alaska Natives.

### Inpatient Care
The hospice services provided by an inpatient facility to a person who has been admitted to a hospital, nursing facility, or facility of a hospice that provides care 24 hours a day.

### Interdisciplinary Group
A group of qualified individuals with expertise in meeting the special needs of hospice clients and their families. The group must include a doctor of medicine or osteopathy, a registered nurse, a social worker and a pastoral or other counselor.

### Internal Control Number (ICN)
The unique number assigned to each claim transaction that is used for tracking.

### Investigational
A non-covered item or service that researchers are studying to investigate how it affects health.

### Mass Adjustment
Adjustments made to multiple claims at the same time. They generally occur when the Department has a change of policy or fees that is retroactive, or when a system error that affected claims processing is identified.

### Medicaid
A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

### Medically Necessary
A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

### Medicare
The federal health insurance program for certain aged or disabled clients.

### Mental Health Services Plan (MHSP)
This plan is for clients who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible

for Medicaid, and have a family income that does not exceed an amount established by the Department.

### Newsletter
An informational letter sent to providers (such as the *Montana Medicaid Claim Jumper* or the *PASSPORT to Health Provider Newsletter*).

### Nursing Facility Services
Services provided by a nursing facility in accordance with 42 CFR, Part 483, Subpart B.

### Palliative Care
Care directed at managing the symptoms experienced by the hospice client, which is intended to enhance the quality of life for the hospice client and the client's family, but not directed at curing the disease.

### PASSPORT Authorization Number
This number is either the PASSPORT provider's PASSPORT number or Medicaid provider ID. When a PASSPORT provider refers a client to another provider for services, this number is given to the other provider and is required when processing the claim.

### PASSPORT To Health
A Medicaid managed care program where the client selects a primary care provider who manages the client's health care needs.

### Patient Contribution
Also called *personal resource*, this is the total of all of the resident's income from any source available to pay for the cost of care, less the resident' personal needs allowance of $40.00.

### Pay and Chase
Medicaid pays a claim and then recovers payment from the third party carrier that is financially responsible for all or part of the claim.

### Pending Claim
These claims have been entered into the system, but have not reached final disposition. They require either additional review or are waiting for client eligibility information.

### Personal Resource
Also called *patient contribution*, this is the total of all of the resident's income from any source available to pay for the cost of care, less the resident' personal needs allowance of $40.00.

### Potential Third Party Liability
Any entity that may be liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

### Prior Authorization (PA)
The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

### Provider or Provider of Service
An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the Department.

### Rebilling
When a provider submits a claim that was previously submitted for payment but was either returned or denied.

### Referral
When providers refer clients to other Medicaid providers for medically necessary services that they cannot provide.

### Remittance Advice (RA)
Provides details of all transactions that have occurred during the previous two weeks, includes paid, denied, and pending claims.

### Remittance Advice Notice
The first page of the remittance advice that contains important messages for providers.

### Representative
A person who is authorized in accordance with state law to execute or revoke an election for hospice care or terminate medical care on behalf of the terminally ill client.

### Resident
A person admitted to a nursing facility who has been present in the facility for at least one 24-hour period.

### Respite Care
Short-term inpatient care in a hospital or nursing facility provided to the client only when necessary to relieve the family members or other persons caring for the client.

### Retroactive Eligibility
When a client is determined to be eligible for Medicaid effective prior to the current date.

### Routine Home Care
Each day the client is at home, under the care of the hospice and not receiving continuous home care.

### Sanction
The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

### Social Worker
A person who has at least a bachelor's degree from a program accredited by the Council on Social Work Education and is working under the direction of a physician.

### Terminally Ill
A life expectancy of six months or less, which is certified by a physician in writing.

### Third Party Liability (TPL)
Any entity that is liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

### Timely Filing
Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) to Medicaid within the latest of

- 12 months from whichever is later:
    - the date of service
    - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

### Virtual Human Services Pavilion (VHSP)
This internet site contains a wealth of information about Human Services, Justice, Commerce, Labor & Industry, Education, voter registration, the Governor's Office, and Montana. http://vhsp.dphhs.state.mt.us

# Index

## D



## E

## F



## G



## H

## I



## K



## L



## M



## N

## O



## P



## Q



## R

## S



## T



## U



## V



## W